The Medicare+Choice payment system

Presentation to Senate Committee on Finance staff

March 7, 2003

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MEDPAC Medicare Payment Advisory Commission

Key points

- The M+C program and other capitated Medicare plans
- How the payment system works
- Issues
  - Geographic variation
  - Lack of new choices
  - Cost

Overview of M+C program

- 4.6 million M+C enrollees
  - (11% of all Medicare beneficiaries)
- Program spending of $35B in FY2002
  - (15% of Medicare total)
- 145 M+C contracts

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Which beneficiaries may enroll in an M+C plan

- Beneficiaries may only enroll in plans that serve their county of residence
- Aged and disabled beneficiaries may enroll, but there are limitations on beneficiaries with ESRD

What does it mean when a beneficiary enrolls in an M+C plan?

- Beneficiaries enroll in advance and may disenroll at the end of any month
- When enrolled, beneficiaries forgo traditional Medicare FFS benefits
- Beneficiaries receive all Medicare services (and often supplemental benefits) from the plan and are liable for plan premiums and copayments
- Beneficiaries pay Part B premium

Products in M+C and other Medicare capitated programs

- M+C
  - HMOs
  - Private FFS plans
  - Specialized plans (PACE, SHMO, Evercare)
  - PPO demonstration plans
- Other programs
  - Cost plans

Medicare cost contract plans

- Plans are paid their actual cost for covered services delivered to members
- Plans must charge premiums for any additional benefits provided
- Members may also use the traditional Medicare program for covered services
- Currently, there are 30 plans with about 335,000 members
- Program expires at the end of 2004

How the M+C payment system works

- Payments are made prospectively to plans monthly for each enrollee
- Payment depends on the enrollee's county of residence and demographic and health risk factors
  - Monthly rate = county rate * risk factor

M+C county payment rates

- Separate rates for aged, disabled, and ESRD
- Updated annually in January (update announced in previous May)
- Maximum of:
  - Minimum update over previous year's rate
  - Applicable floor rate
  - Local/national blended rate

Minimum update over previous year's rate

- Current law sets the minimum update to 2%
- Legislatively changed to 3% for 2001 only
- Update is a minimum, not a limit

Floor rates

- Two floors
  - Counties in large urban areas - $547.54
    - 31% of beneficiaries, 32% M+C enrollees
  - Other counties – $495.39
    - 23% of beneficiaries, only 2% of M+C enrollees
- Updated annually by national growth in per capita Medicare FFS spending

Local/national blended rates

- Blend is 50/50 local/national
- Local rate
  - Based on 1997 rate (AAPCC) with graduate medical education payments removed
  - Updated annually by national growth in per capita Medicare FFS spending (reduced by legislation for 1998-2002)
- National rate – beneficiary weighted average of local rates
- Budget neutrality – rates only paid for 2000

Risk adjustment

- Pre-BBA demographic factors are still being used
- PIP-DCG hospital diagnosis model also being used for 2003
- New multi-site CMS-HCC diagnosis model will be phased in beginning in 2004 and will be the only model by 2007

Demographic system

- Each beneficiary is placed into a rate cell based on their:
  - Age
  - Sex
  - Medicaid status
  - Institutionalized status
  - Working/Non-working status
  - Aged/Disabled

PIP-DCG

- Each beneficiary's rate is based on:
  - Age
  - Sex
  - Medicaid status
  - Previously disabled
  - First-year enrollee
  - PIP-DCG group
- Affects 10% of payment and will not be used after 2003

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New CMS-HCC model

- Final model will be announced in May
- Beneficiaries will be placed in rate cells based on age, sex, prior disability, Medicaid status, and working status
- Additional payments made for each of 61 specified health conditions diagnosed in the previous year
- Separate models for ESRD dialysis and transplant patients, first-year beneficiaries, and special plans for the frail elderly

Hypothetical payment example

- 82-year old woman in Houston with diabetes and a cerebral hemorrhage
  - Risk score = 3.2 – 82-year old woman
  - + 3.0 – cerebral hemorrhage
  - + 1.8 – diabetes
  - 8.0
  - Harris county rate in 2003 = $676.82
  - Monthly payment = $676.82*8.0=$5,414.56

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Variability in payment rates

- For 2003, payment rates vary from $510 in 2,014 floor counties to $873 in Staten Island
- In 1997, the rates varied from $220 to $767

History of M+C withdrawals

	Enrollees affected	Percent of all enrollees	w/no M+C CCP avail.	Percent of all enrollees
1999	407,000	7	51,000	1
2000	327,000	5	79,000	1
2001	934,000	15	159,000	3
2002	536,000	10	88,000	2
2003	198,000	4	36,000	1

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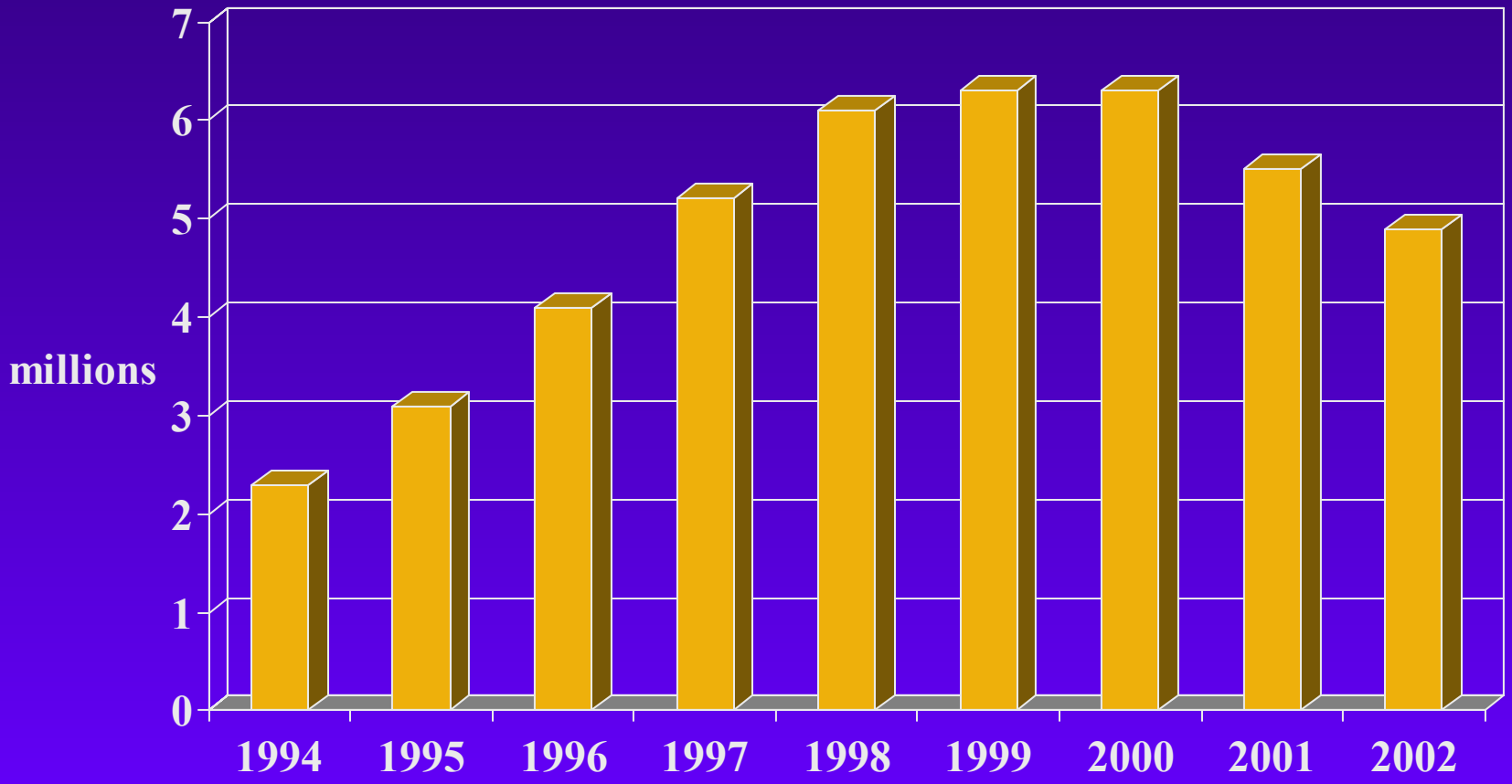
Enrollment in M+C (or risk) plans 1994-2002



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Availability of plans in 2003

	Percent of beneficiaries	M+C CCP	PFFS	PPO demo	Cost contracts	Any plan
National	100%	58%	36%	23%	23%	80%
County payment rate						
Floor	55	40	50	15	16	74
Large urban floor	31	61	43	24	19	82
Other floor	23	12	58	3	12	63
Non-floor	45	80	20	32	30	86
Rural areas	23	13	56	4	9	61
Urban areas	77	72	30	28	25	85

Note: CCP (coordinated care plan), M+C (Medicare+Choice), PFFS (private fee-for-service), PPO (preferred provider organization)
Source: MedPAC analysis of data from CMS website, August 2002 and September 2002.

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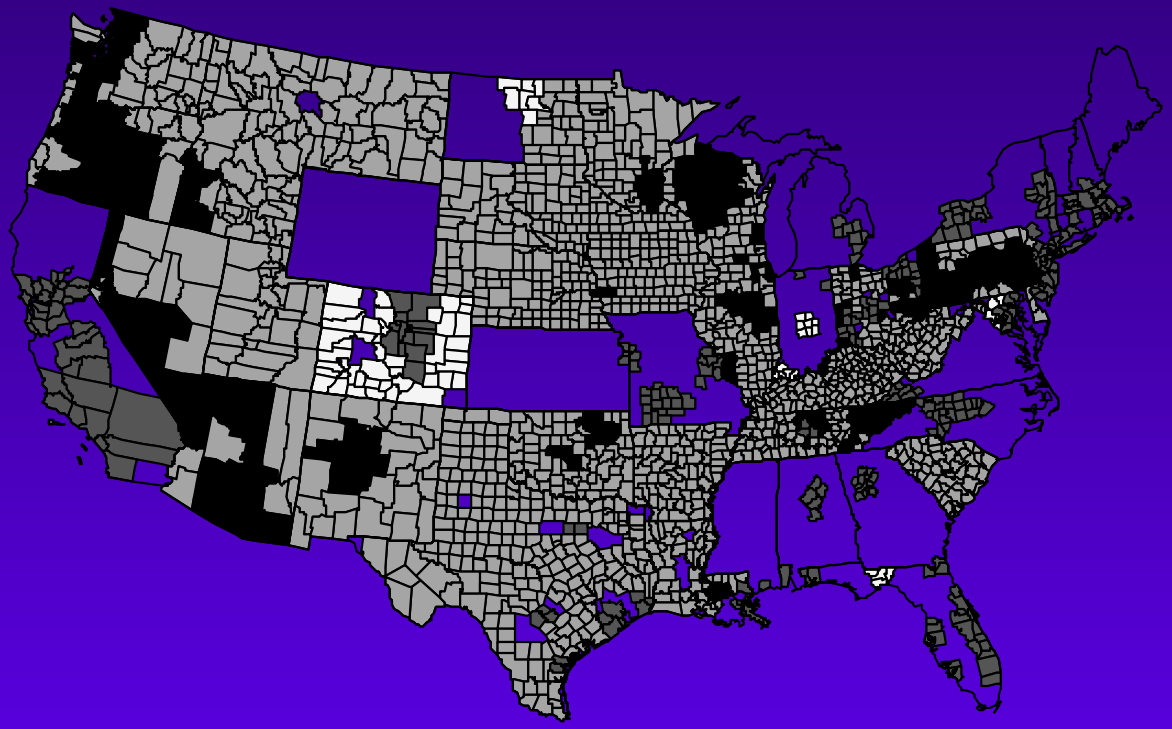
M+C plan benefit erosion

- In 1999, 78% of enrollees were in plans with zero premiums that offered drug coverage and 1.1 million enrollees had unlimited drug coverage
- Currently, 28% of enrollees are in plans with zero premiums that offer drug coverage and 86 thousand enrollees have unlimited drug coverage

Counties with M+C plans, 2003



None
CCP only
PFFS only
CCP and PFFS

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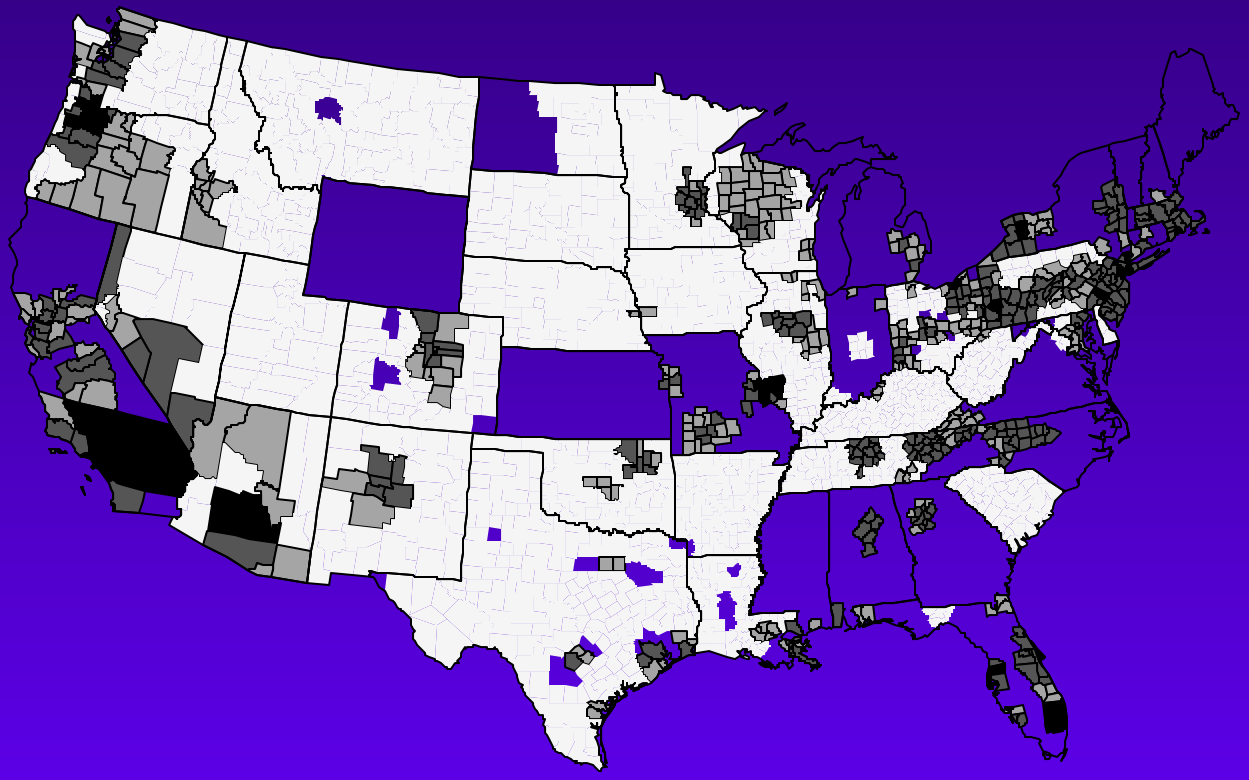
Coordinated Care Plans in M+C



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Cost of plans exceeds FFS

- Two-thirds of Medicare beneficiaries and M+C enrollees live in counties where CMS projects FFS spending is lower than M+C rates for 2003
- Overall the Medicare program pays 104 percent of the FFS cost for the current mix of M+C enrollees, before accounting for risk differences

Current project

- Examining Medicare health insurance markets
  - Looking at local levels
  - Including Medigap, employer sponsored, M+C, and Medicaid
  - Thinking about lessons from the private sector that might be applied to Medicare